Obesity Medicine Fellowship Council

Obesity Medicine Fellowship Application

Personal Information

* = the field is required

Contact Information

First Name*

Middle Name

Last Name*

Previous Last Name

Suffix

Preferred Name

Last 4 digits of SSN

Preferred Phone*

Mobile Phone

Alternate Phone

Fax

Pager

Email*

Address

Current Mailing Address

Address 1*

Address 2

Country*

State

(Required for U.S. & Canadian addresses)

City*

Postal Code

Is your permanent address the same as your current mailing address?* ☐ Yes ☐ No

Permanent Address

Address 1

Address 2

Country

State

City

Postal Code

Phone

Citizenship Information

Are you a U.S. citizen?* ☐ Yes ☐ No

If yes, are you a citizen of a country in addition to the United States? ☐ Yes ☐ No

If yes, enter your country of dual citizenship (other than the U.S.): _____

If you are not a U.S. citizen, select citizenship status:

- ☐ Permanent Resident (Green Card Holder)
- ☐ Conditional Permanent Resident
- ☐ Refugee/Asylum/Displaced Person
- ☐ Pending Application for Permanent Resident
- ☐ Foreign National Residing Outside of the U.S.
- ☐ Foreign national Currently in the U.S. with Valid Visa Status

If you are a Foreign National currently in in the U.S. with Valid Visa Status, select your current Visa/Employment Authorization Status:

- ☐ F-1 Academic Student (Employment Authorization Document - Optional Practical Training)
- ☐ F-2 Spouse or Child of F-1
- ☐ H-1 Temporary Worker
- ☐ H-1B Special occupation, DoD worker, etcetera
- ☐ H-2B Temporary worker - skilled and unskilled
- ☐ H-4 spouse or Child of H-1, H-2, H-3
- ☐ J-1 Visa for exchange visitor
- ☐ J-2 Spouse or Child of J-1 Employment Authorization Document (EAD)
- ☐ O-1 Person of Extraordinary Ability in science, arts, education, business or athletics
- ☐ TN NAFTA Trade for Canadians and Mexicans
- ☐ E-2 Treaty Investor, Spouse and Child (EAD)
- ☐ Diplomatic Service
- ☐ Employment Authorization Document (EAD)
- ☐ L-2 Dependent of Intra-Company Transferee (EAD)
- ☐ DACA Deferred Action for Childhood Arrivals
- ☐ Other

If you are a Foreign national, outside the U.S. or currently in the U.S. , with a valid visa status, please respond: Will you need visa sponsorship through the ECFMG (J-1) or the teaching hospital (H-1B) in order to participate in U.S. fellowship training?

☐ Yes ☐ No

If yes, please select the visa(s) you would like to apply for. Select all that apply. ☐ H-1B ☐ J-1

If no, Expected Visa/Employment Authorization Status (the visa status you expect to secure with Employment Authorization to participate in a program):

- ☐ F-1 Academic Student (Employment Authorization Document - Optional Practical Training)
- ☑ F-2 Spouse or Child of F-1
- ☑ H-1 Temporary Worker
- ☑ H-1B Special occupation, DoD worker, etcetera
- ☑ H-2B Temporary worker - skilled and unskilled
- ☑ H-4 spouse or Child of H-1, H-2, H-3
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- ☑ L-2 Dependent of Intra-Company Transferee (EAD)
- ☑ DACA Deferred Action for Childhood Arrivals
- ☑ Other

If applicable, please indicate your state or province of residence in the United States or Canada:

Additional Information

USMLE/ECFMG ID:

NBOME ID: *(Required for D.O. applicants)*

AOA Member Number:

I am ACLS (Advanced Cardiovascular Life Support) certified in the U.S.A.: ☐ Yes ☐ No

If yes, ACLS Expiration Date:

I am PALS (Pediatric Advanced Life Support) certified in the U.S.A.: ☐ Yes ☐ No

If yes, PALS Expiration Date:

I am BLS (Basic Life Support) certified in the U.S.A.: ☐ Yes ☐ No

If yes, BLS Expiration Date:

Sigma Sigma Phi Status: *(D.O. applicants only)*

Alpha Omega Alpha Status:

Gold Humanism Honor Society Status:

Biographic Information

General

Gender* No Response Birth Place Birth Date

Self Identification

If you reside in the European Union, do not answer this question. Please ignore this section.

This section allows you to indicate how you self-identify. When selecting "Other" as a sub-category, the text field is limited to 120 characters but is not required field. If you prefer not to self-identify, please ignore this section.

How do you self-identify? Please select all that apply.

- [ ] Hispanic, Latino or of Spanish origin
  - [ ] Colombian
  - [ ] Argentinean
  - [ ] Cuban
  - [ ] Dominican
  - [ ] Mexican/Chicano
  - [ ] Peruvian
  - [ ] Puerto Rican
  - [ ] Other Hispanic:
- [ ] American Indian or Alaskan Native
  - Tribal affiliation:
- [ ] Asian
  - [ ] Bangladeshi
  - [ ] Cambodian
  - [ ] Chinese
  - [ ] Filipino
  - [ ] Indian
  - [ ] Indonesian
  - [ ] Japanese
  - [ ] Korean
  - [ ] Laotian
  - [ ] Pakistani
  - [ ] Taiwanese
  - [ ] Vietnamese
  - [ ] Other Asian:
- [ ] Black or African American
  - [ ] African American
  - [ ] Afro-Caribbean
  - [ ] African
  - [ ] Other Black:
- [ ] Native Hawaiian or Pacific Islander
  - [ ] Guamanian
  - [ ] Native Hawaiian
  - [ ] Samoan
  - [ ] Other Pacific Islander:
- [x] White
- [ ] Other:

Language Fluency

What languages do you speak? Select all that apply. For each language that you select, including English, you will be asked to rate your proficiency in that language using the guidelines provided below.*

Native/Functionally Native: I converse easily and accurately in all types of situations. Native speakers, including highly educated, may think that I am a native speaker, too.

Advanced: I speak very accurately, and I understand other speakers very accurately. Native speakers have no problem understanding me, but they probably perceive that I am not a native speaker.

Good: I speak well enough to participate in most conversations. Native speakers notice some errors in my speech or my understanding, but my errors rarely cause misunderstanding. I have some difficulty communicating necessary health concepts.

Fair: I speak and understand well enough to have extended conversations about current events, work, family, or personal life. Native speakers notice many errors in my speech or my understanding. I have difficulty communicating about healthcare concepts.

Basic: I speak the language imperfectly and only to a limited degree and in limited situations. I have difficulty in or understanding extended conversations. I am unable to understand or communicate most healthcare concepts.

- ☐ Afrikaans
- ☐ Albanian
- ☐ American Sign Language
- ☐ Amharic
- ☐ Arabic
- ☐ Armenian
- ☐ Bantu
- ☐ Bengali
- ☐ Bulgarian
- ☐ Burmese
- ☐ Cajun
- ☐ Chinese
- ☐ Croatian
- ☐ Cushite
- ☐ Czech
- ☐ Danish
- ☐ Dutch
- ☐ English
- ☐ Finnish
- ☐ Formosan
- ☐ French
- ☐ French Creole
- ☐ German
- ☐ Greek
- ☐ Gujarati
- ☐ Hebrew
- ☐ Hindi
- ☐ Hmong
- ☐ Hungarian
- ☐ Ilocano
- ☐ Indonesian
- ☐ Italian
- ☐ Japanese
- ☐ Kannada
- ☐ Korean
- ☐ Kru, lbo, Yoruba
- ☐ Laotian
- ☐ Lithuanian
- ☐ Malayalam
- ☐ Mande
- ☐ Marathi
- ☐ Mon-Khmer, Cambodian
- ☐ Navajo
- ☐ Nepali
- ☐ Norwegian
- ☐ Patois
- ☐ Pennsylvania Dutch
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Romanian
- ☐ Russian
- ☐ Samoan
- ☐ Serbian
- ☐ Serbocroatian
- ☐ Sinhalese
- ☐ Slovak
- ☐ Spanish/Spanish Creole
- ☐ Swahili
- ☐ Swedish
- ☐ Syriac
- ☐ Tagalog
- ☐ Tamil
- ☐ Telugu
- ☐ Thai
- ☐ Tongan
- ☐ Turkish
- ☐ Ukrainian
- ☐ Urdu
- ☐ Vietnamese
- ☐ Yiddish

Military Information

Are you committed to fulfill a U.S. military active duty service obligations/deferments?* ☐ Yes ☐ No

If yes, number of years remaining | Branch

Do you have any other service obligations? (e.g. - Military Reserves, Public Health/State programs, etc.)* ☐ Yes ☐ No

If yes, describe
255 Character Max

Additional Information

Hobbies & Interests
510 Character Max

Education

Higher Education

This section allows multiple entries for each Undergraduate and Graduate School you have attached.

Since most non-U.S. educational systems do not follow the U.S. model, almost all students and graduates of international medical schools will indicate "None".

☐ None

Entry 1

Institution*

Location*

Education Type* (undergraduate, graduate, etc.)

Field of Study*

Degree expected or earned* (yes/no)

Dates of Attendance: From Month* | From Year* | To Month* | To Year*

Entry 2

Institution*

Location*

Education Type*

Field of Study*

Degree expected or earned*

Dates of Attendance: From Month* | From Year* | To Month* | To Year*

Medical Education

This section allows entries for each Medical School you have attended.

Entry 1

Country*

Institution*

Degree*

Degree Month* Degree Year*

Dates of Education*

From Month* From Year* To Month* To Year*

Entry 2

Country*

Institution*

Degree*

Degree Month* Degree Year*

Dates of Education

From Month* From Year* To Month* To Year*

Additional Information

Membership in Honorary/ Professional Societies
255 Characters Max

Medical School Awards
510 Characters Max

Other Awards/ Accomplishments
510 Characters Max

Experience

Training

Please add an entry for any current or prior AOA Internship, AOA Residency, AOA Fellowship, ACGME Residency or ACGME/RCPSC/ UCNS Fellowship in which you have trained, regardless of the length of time spent in the training. Additional entries may be added as needed.

☐ None

Entry 1

Type of Training*

Specialty*

Institution/Program*

Country*

State/Province

City*

Program Director*

Supervisor*

☐ Chief Resident

Dates of Residency/Fellowship

From Month* From Year* To Month* To Year*

Reason for Leaving
510 Characters Max

Entry 2

Type of Training*

Specialty*

Institution/Program*

Country*

State/Province

City*

Program Director*

Supervisor*

☐ Chief Resident

Dates of Residency/Fellowship

From Month* From Year* To Month* To Year*

Reason for Leaving
510 Characters Max

Experience

Please add your additional experience. Clinical and Teaching experience should be treated as Work experiences. Include all unpaid extra -curricular activities and committees you have served on as a Volunteer experiences.

☐ None

Entry 1

Experience Type*

Organization*

Position*

Supervisor

Country*

State/Province

City*

Average Hours/Week

Description
1020 Characters Max

Reason for Leaving
510 Characters Max

Dates of Experience

From Month* From Year* To Month* To Year*

Entry 2

Experience Type*

Organization*

Position*

Supervisor

Country*

State/Province

City*

Average Hours/Week

Description
1020 Characters Max

Reason for Leaving
510 Characters Max

Dates of Experience

From Month* From Year* To Month* To Year*

Additional Questions

Was your medical education/training extended or interrupted?* ☐ Yes ☐ No

If yes, please provide details.
510 Characters Max

Licensure

Please add an entry for any of your state medical licenses.

☐ None

Entry 1

State*

License Type*

License Number*

Expiration Month*

Expiration Year*

Entry 2

State*

License Type*

License Number*

Expiration Month*

Expiration Year*

Additional Information

Has your medical license ever been suspended/revoked/voluntarily terminated?* ☐ Yes ☐ No

If yes, please explain:

Have you been named in a malpractice case?* ☐ Yes ☐ No

If yes, please explain:

Is there anything in your past history that would limit your ability to be licensed or would limit you ability to receive hospital privileges?* ☐ Yes ☐ No

If yes, please explain:

Have you ever been convicted of a misdemeanor in the United States?* ☐ Yes ☐ No

If yes, please explain:

Have you ever been convicted of a felony in the United States?* ☐ Yes ☐ No

If yes, please explain:

Are you able to carry out the responsibilities of a resident or a fellow in the specialties and at the specific training programs to which you are applying, including the functional requirements, cognitive requirements, interpersonal and communication requirements with or without reasonable accommodations?* ☐ Yes ☐ No ☐ No Response

If no, please list your limiting aspect(s):

Are you Board Certified?* ☐ Yes ☐ No

If yes, Board Name

DEA Registration Number

To complete your application, please include: Curriculum Vitae, Personal Statement, Transcripts of National Board Exams, a photo, and three letters of recommendation (from the director of your residency program, your most recent supervisor other than your residency program director, and one additional letter from a clinical supervisor who can attest to the strengths of the applicant).

☐ I certify that the information contained within the application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position; or if employed, may constitute cause for termination from the program.

☐ I understand that if I am accepted to a fellowship program and agree to attend, I am obligated to begin that fellowship program on the agreed upon date.